STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155664	A. BUILDING _____ B. WING _____	C 11/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHAB- EAGLE CREEK	4102 SHORE DR INDIANAPOLIS, IN 46254

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

This visit was for the Investigation of Complaints IN00136364, IN00136393, IN00136405, IN00136448, IN00138957, and IN00139626.

Complaint IN00136364 Substantiated. No deficiencies related to the allegations are cited.

Complaint IN00136393 Unsubstantiated due to lack of evidence.

Complaint IN136405 Substantiated. No deficiencies related to the allegations are cited.

Complaint IN00136448 Unsubstantiated due to lack of evidence.

Complaint IN00138597 Unsubstantiated due to lack of evidence.

Complaint IN00139626 Substantiated. No deficiencies related to the allegations are cited.

Survey dates: November 19, 20, 21, 22, 2013

Facility number: 010666
Provider number: 155664
AIM number: 200229930

Survey team:
Connie Landman RN-TC
Joyce Hoffman RN (November 20, 21, 22, 2013)

Census bed type:
SNF/NF: 100
Total: 100

Census payor type:

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155664	A. BUILDING _____ B. WING _____	C 11/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHAB- EAGLE CREEK	4102 SHORE DR INDIANAPOLIS, IN 46254

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 1 Medicare: 39 Medicaid: 37 Other: 24 Total: 100 Sample: 10 Kindred Transitional Care and Rehab - Eagle Creek was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2 in regard to the Investigation of Complaints IN00136364, IN00136393, IN00136405, IN00136448, IN00138957, and IN00139626. Quality Review 11/25/13 by Lisa McColly	F 000		